State: *District of Columbia* ***Filing Company:*** *Delta Dental Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health Dental*
Product Name: *DC, DDIC, Amex dc, form*
Project Name/Number: *DC, DDIC, Amex dc, form/DC, DDIC, Amex dc, form*

Filing at a Glance

Company:	Delta Dental Insurance Company
Product Name:	DC, DDIC, Amex dc, form
State:	District of Columbia
TOI:	H10G Group Health - Dental
Sub-TOI:	H10G.000 Health Dental
Filing Type:	Form
Date Submitted:	10/21/2015
SERFF Tr Num:	DDPA-130294232
SERFF Status:	Closed-FILED FOR INFORMATION
State Tr Num:	
State Status:	
Co Tr Num:	DC, DDIC, AMEX DC, FORM
Implementation Date Requested:	01/01/2016
Author(s):	Ashley Singer, Connie Roth, Noel Brennan, Debra LeRiche, Alisa Koelling, Brandy Christian
Reviewer(s):	Andre Beard (primary)
Disposition Date:	11/02/2015
Disposition Status:	FILED FOR INFORMATION
Implementation Date:	11/02/2015

State: *District of Columbia* **Filing Company:** *Delta Dental Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health Dental*
Product Name: *DC, DDIC, Amex dc, form*
Project Name/Number: *DC, DDIC, Amex dc, form/DC, DDIC, Amex dc, form*

General Information

Project Name: DC, DDIC, Amex dc, form
Project Number: DC, DDIC, Amex dc, form
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Association, Trust, Other
Overall Rate Impact:

Deemer Date:
Submitted By: Alisa Koelling

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Explanation for Other Group Market Type: Labor Union
Filing Status Changed: 11/02/2015
State Status Changed:
Created By: Alisa Koelling
Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval are new benefit, limitation and exclusion Schedules S-A-D70-R16 and S-B-D70 for the DeltaCare® USA Program. The forms do not replace any on file with your Department. This filing is not ACA/PPACA related.

These forms will be used in conjunction with the Evidence of Coverage DC-DDIC-EOC(CDT4R), approved by the Department on July 6, 2004 and Contract MC-DDIC-DC(CDT4R), approved by the Department on July 6, 2004.

Schedules S-A-D70-R16, Description of Benefits and Copayments, and S-B-D70, Limitations and Exclusions of Benefits, are for use when our DeltaCare USA programs are sold to employer/employee, labor union or association groups located in the District of Columbia. These forms will not be used as or with an individual policy. These Schedules will be automatically updated annually for any changes required by the American Dental Association.

Addresses, phone numbers, websites, page numbers and numerical data are variable unless required by law. The schedules are bracketed in their entirety to allow for the addition and/or removal of procedures as well as modifications to the copayment ranges or frequencies at the request of groups who may require we change the benefit structure. In no event would any Schedule be completely removed.

The effective date for use of these forms will be the earlier of January 1, 2016 or the date the filing is approved or deemed approved by your Department.

Thank you for reviewing our filing. Please do not hesitate to contact me with any questions or concerns at (916) 861-1974 or akoelling@delta.org.

Sincerely,
Alisa Koelling
Regulatory Analyst

Company and Contact

Filing Contact Information

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State: *District of Columbia* ***Filing Company:*** *Delta Dental Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health Dental*
Product Name: *DC, DDIC, Amex dc, form*
Project Name/Number: *DC, DDIC, Amex dc, form/DC, DDIC, Amex dc, form*

Filing Company Information

Delta Dental Insurance Company
1130 Sanctuary Parkway
Suite 600
Alpharetta, GA 30009
(770) 641-5217 ext. [Phone]

CoCode: 81396
Group Code: 2479
Group Name:
FEIN Number: 94-2761537

State of Domicile: Delaware
Company Type: LAH
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*DDPA-130294232*	***State Tracking #:***		***Company Tracking #:***	*DC, DDIC, AMEX DC, FORM*

State:	*District of Columbia*	***Filing Company:***	*Delta Dental Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health Dental*		
Product Name:	*DC, DDIC, Amex dc, form*		
Project Name/Number:	*DC, DDIC, Amex dc, form/DC, DDIC, Amex dc, form*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
FILED FOR INFORMATION	Andre Beard	11/02/2015	11/02/2015

SERFF Tracking #:	*DDPA-130294232*	***State Tracking #:***		***Company Tracking #:***	*DC, DDIC, AMEX DC, FORM*

State:	*District of Columbia*	***Filing Company:***	*Delta Dental Insurance Company*
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Product Name:	*DC, DDIC, Amex dc, form*		
Project Name/Number:	*DC, DDIC, Amex dc, form/DC, DDIC, Amex dc, form*		

Disposition

Disposition Date: 11/02/2015
Implementation Date: 11/02/2015
Status: FILED FOR INFORMATION

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Statement of Variability	FILED FOR INFORMATION ONLY/NO APPROVAL	Yes
Supporting Document	Previously Approved Forms	FILED FOR INFORMATION ONLY/NO APPROVAL	Yes
Supporting Document	Cover Letter	FILED FOR INFORMATION ONLY/NO APPROVAL	Yes
Form	Schedule A Description of Benefits and Copayments	FILED FOR INFORMATION ONLY/NO APPROVAL	Yes
Form	Schedule B Limitations and Exclusions of Benefits	FILED FOR INFORMATION ONLY/NO APPROVAL	Yes

SERFF Tracking #:	*DDPA-130294232*	***State Tracking #:***		***Company Tracking #:***	*DC, DDIC, AMEX DC, FORM*

State:	*District of Columbia*	***Filing Company:***	*Delta Dental Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health Dental*		
Product Name:	*DC, DDIC, Amex dc, form*		
Project Name/Number:	*DC, DDIC, Amex dc, form/DC, DDIC, Amex dc, form*		

Form Schedule

Lead Form Number: S-A-D70-R16

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	FILED FOR INFORMATION ONLY/NO APPROVAL 11/02/2015	Schedule A Description of Benefits and Copayments	S-A-D70-R16	SCH	Initial			S-A-D70-R16 Clean 101915.pdf
2	FILED FOR INFORMATION ONLY/NO APPROVAL 11/02/2015	Schedule B Limitations and Exclusions of Benefits	S-B-D70	SCH	Initial			S-B-D70 Clean 101915.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

[[AS1]**SCHEDULE A**

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA Program and is not to be interpreted as CDT-2016 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	$0.00
D0140	Limited oral evaluation - problem focused	$0.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation - new or established patient	$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0.00
D0171	Re-evaluation - post-operative office visit	$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	$40.00
D0190	Screening of a patient	$0.00
D0191	Assessment of a patient	$0.00
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	$0.00
D0220	Intraoral - periapical first radiographic image	$0.00
D0230	Intraoral - periapical each additional radiographic image	$0.00
D0240	Intraoral - occlusal radiographic image	$0.00
D0270	Bitewing - single radiographic image	$0.00
D0272	Bitewings - two radiographic images	$0.00
D0273	Bitewings three radiographic images	$0.00
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	$0.00
D0277	Vertical bitewings - 7 to 8 radiographic images	$0.00
D0330	Panoramic radiographic image	$0.00
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50.00
D0460	Pulp vitality tests	$11.00
D0470	Diagnostic casts	$0.00
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0.00
D0601	Caries risk assessment and documentation, with a finding of low risk - *limited to children age 3 to 19, 1 every 3 years*	$0.00
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *limited to children age 3 to 19, 1 every 3 years*	$0.00
D0603	Caries risk assessment and documentation, with a finding of high risk - *limited to children age 3 to 19, 1 every 3 years*	$0.00
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$0.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis cleaning - adult – *limited to 2 per calendar year*	$0.00
D1110	*Additional prophylaxis cleaning - adult (within the 12 month period)*	*$45.00*
D1120	Prophylaxis cleaning - child - *limited to 2 per calendar year*	$0.00
D1120	*Additional prophylaxis cleaning - child (within the 12 month period)*	*$30.00*
D1206	Topical application of fluoride varnish - *child to age 19; 2 D1206 or D1208 per calendar year*	$0.00
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 2 D1206 or D1208 per calendar year*	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$15.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$15.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$15.00
D1354	Interim caries arresting medicament application - *child to age 19; 2 per calendar year*	$0.00
D1510	Space maintainer - fixed - unilateral	$95.00
D1515	Space maintainer - fixed - bilateral	$155.00
D1555	Removal of fixed space maintainer	$0.00

D2000-D2999 III. RESTORATIVE

- *Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.*
- *When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $130.00 per crown, beyond the 6th unit.*
- *Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.*

D2140	Amalgam - one surface, primary or permanent	$16.00
D2150	Amalgam - two surfaces, primary or permanent	$21.00
D2160	Amalgam - three surfaces, primary or permanent	$26.00
D2161	Amalgam - four or more surfaces, primary or permanent	$32.00
D2330	Resin-based composite - one surface, anterior	$21.00
D2331	Resin-based composite - two surfaces, anterior	$26.00
D2332	Resin-based composite - three surfaces, anterior	$32.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$80.00
D2390	Resin-based composite crown, anterior	$105.00
D2391	Resin-based composite - one surface, posterior	$42.00
D2392	Resin-based composite - two surfaces, posterior	$53.00
D2393	Resin-based composite - three surfaces, posterior	$74.00
D2394	Resin-based composite - four or more surfaces, posterior	$100.00
D2510	Inlay - metallic - one surface	$410.00
D2520	Inlay - metallic - two surfaces	$410.00
D2530	Inlay - metallic - three or more surfaces	$410.00
D2542	Onlay - metallic - two surfaces	$470.00
D2543	Onlay - metallic - three surfaces	$470.00
D2544	Onlay - metallic - four or more surfaces	$470.00
D2740	Crown - porcelain/ceramic substrate	$505.00
D2750	Crown - porcelain fused to high noble metal	$460.00
D2751	Crown - porcelain fused to predominantly base metal	$405.00
D2752	Crown - porcelain fused to noble metal	$430.00
D2780	Crown - ¾ cast high noble metal	$460.00
D2781	Crown - ¾ cast predominantly base metal	$405.00
D2782	Crown - ¾ cast noble metal	$430.00
D2790	Crown - full cast high noble metal	$460.00
D2791	Crown - full cast predominantly base metal	$405.00
D2792	Crown - full cast noble metal	$430.00

D2794	Crown - titanium	$460.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$41.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$41.00
D2920	Re-cement or re-bond crown	$41.00
D2921	Reattachment of tooth fragment, incisal edge or cusp (anterior)	$80.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - anterior	$98.00
D2930	Prefabricated stainless steel crown - primary tooth	$98.00
D2931	Prefabricated stainless steel crown - permanent tooth	$98.00
D2932	Prefabricated resin crown - anterior primary tooth	$120.00
D2933	Prefabricated stainless steel crown with resin window - anterior primary tooth	$145.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$145.00
D2940	Protective restoration	$13.00
D2941	Interim therapeutic restoration - primary dentition	$13.00
D2949	Restorative foundation for an indirect restoration	$98.00
D2950	Core buildup, including any pins when required	$98.00
D2951	Pin retention - per tooth, in addition to restoration	$21.00
D2952	Post and core in addition to crown, indirectly fabricated - includes canal preparation	$155.00
D2954	Prefabricated post and core in addition to crown - base metal post; includes canal preparation	$130.00
D2960	Labial veneer (resin laminate) – chairside	$95.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$15.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	$33.00
D3120	Pulp cap - indirect (excluding final restoration)	$33.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$78.00
D3221	Pulpal debridement, primary and permanent teeth	$78.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$78.00
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration)	$315.00
D3320	Root canal - endodontic therapy, bicuspid tooth (excluding final restoration)	$370.00
D3330	Root canal - endodontic therapy, molar (excluding final restoration)	$505.00
D3331	Treatment of root canal obstruction; non-surgical access	$135.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$135.00
D3333	Internal root repair of perforation defects	$135.00
D3346	Retreatment of previous root canal therapy - anterior	$420.00
D3347	Retreatment of previous root canal therapy - bicuspid	$475.00
D3348	Retreatment of previous root canal therapy - molar	$605.00
D3410	Apicoectomy - anterior	$375.00
D3421	Apicoectomy - bicuspid (first root)	$405.00
D3425	Apicoectomy - molar (first root)	$430.00
D3426	Apicoectomy (each additional root)	$145.00
D3427	Periradicular surgery without apicoectomy	$375.00
D3430	Retrograde filling - per root	$100.00

D4000-D4999 V. PERIODONTICS

- *Includes preoperative and postoperative evaluations and treatment under a local anesthetic.*

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$120.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$120.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$295.00

D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$155.00
D4245	Apically positioned flap	$295.00
D4249	Clinical crown lengthening - hard tissue	$325.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$595.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$310.00
D4263	Bone replacement graft - first site in quadrant	$290.00
D4264	Bone replacement graft - each additional site in quadrant	$225.00
D4266	Guided tissue regeneration - resorbable barrier, per site	$380.00
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	$430.00
D4270	Pedicle soft tissue graft procedure	$395.00
D4275	Non-autogenous connective tissue graft (including recipient site and donor material), first tooth, implant or edentulous tooth position in graft	$395.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant or edentulous tooth position in graft	$395.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site	$198.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	$237.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$110.00
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	$61.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*	$83.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$45.00
D4910	Periodontal maintenance - *limited to 2 per calendar year*	$78.00
D4921	Gingival irrigation - per quadrant	$0.00

D5000-D5899 VI. PROSTHODONTICS (removable)

- *For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.*
- *Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.*
- *Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.*

D5110	Complete denture - maxillary	$550.00
D5120	Complete denture - mandibular	$550.00
D5130	Immediate denture - maxillary	$550.00
D5140	Immediate denture - mandibular	$550.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$410.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$410.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$640.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$640.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$410.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$410.00

D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$640.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$640.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$410.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$410.00
D5410	Adjust complete denture - maxillary	$33.00
D5411	Adjust complete denture - mandibular	$33.00
D5421	Adjust partial denture - maxillary	$33.00
D5422	Adjust partial denture - mandibular	$33.00
D5510	Repair broken complete denture base	$65.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$65.00
D5610	Repair resin denture base	$65.00
D5630	Repair or replace broken clasp - per tooth	$82.00
D5640	Replace broken teeth - per tooth	$65.00
D5650	Add tooth to existing partial denture	$65.00
D5660	Add clasp to existing partial denture - per tooth	$82.00
D5710	Rebase complete maxillary denture	$195.00
D5711	Rebase complete mandibular denture	$195.00
D5720	Rebase maxillary partial denture	$195.00
D5721	Rebase mandibular partial denture	$195.00
D5730	Reline complete maxillary denture (chairside)	$115.00
D5731	Reline complete mandibular denture (chairside)	$115.00
D5740	Reline maxillary partial denture (chairside)	$115.00
D5741	Reline mandibular partial denture (chairside)	$115.00
D5750	Reline complete maxillary denture (laboratory)	$170.00
D5751	Reline complete mandibular denture (laboratory)	$170.00
D5760	Reline maxillary partial denture (laboratory)	$170.00
D5761	Reline mandibular partial denture (laboratory)	$170.00
D5810	Interim complete denture (maxillary)	$295.00
D5811	Interim complete denture (mandibular)	$295.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	$235.00
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	$235.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- *When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $130.00 per unit, beyond the 6th unit.*
- *Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.*

D6210	Pontic - cast high noble metal	$460.00
D6211	Pontic - cast predominantly base metal	$405.00
D6212	Pontic - cast noble metal	$430.00
D6214	Pontic – titanium	$460.00
D6240	Pontic - porcelain fused to high noble metal	$460.00
D6241	Pontic - porcelain fused to predominantly base metal	$405.00
D6242	Pontic - porcelain fused to noble metal	$430.00
D6245	Pontic - porcelain/ceramic	$450.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$460.00

D6603	Retainer inlay - cast high noble metal, three or more surfaces	$460.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$405.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$405.00
D6606	Retainer inlay - cast noble metal, two surfaces	$430.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$430.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$460.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$460.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$405.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$405.00
D6614	Retainer onlay - cast noble metal, two surfaces	$430.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$430.00
D6624	Retainer inlay – titanium	$460.00
D6634	Retainer onlay – titanium	$460.00
D6740	Retainer crown - porcelain/ceramic	$505.00
D6750	Retainer crown - porcelain fused to high noble metal	$460.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$405.00
D6752	Retainer crown - porcelain fused to noble metal	$430.00
D6780	Retainer crown - ¾ cast high noble metal	$460.00
D6781	Retainer crown - ¾ cast predominantly base metal	$405.00
D6782	Retainer crown - ¾ cast noble metal	$430.00
D6790	Retainer crown - full cast high noble metal	$460.00
D6791	Retainer crown - full cast predominantly base metal	$405.00
D6792	Retainer crown - full cast noble metal	$430.00
D6794	Retainer crown – titanium	$460.00
D6930	Re-cement or re-bond fixed partial denture	$62.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- *Includes preoperative and postoperative evaluations and treatment under a local anesthetic.*

D7111	Extraction, coronal remnants - deciduous tooth	$50.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$50.00
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$100.00
D7220	Removal of impacted tooth - soft tissue	$110.00
D7230	Removal of impacted tooth - partially bony	$145.00
D7240	Removal of impacted tooth - completely bony	$220.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$220.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$100.00
D7251	Coronectomy - intentional partial tooth removal	$145.00
D7260	Oroantral fistula closure	$315.00
D7261	Primary closure of a sinus perforation	$315.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$155.00
D7280	Surgical access of an unerupted tooth	$185.00
D7283	Placement of device to facilitate eruption of impacted tooth	$44.00
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$155.00
D7286	Incisional biopsy of oral tissue - soft - does not include pathology laboratory procedures	$120.00
D7287	Exfoliative cytological sample collection	$67.00
D7288	Brush biopsy - transepithelial sample collection	$67.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$100.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$135.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$66.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$170.00

D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$170.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$190.00
D7472	Removal of torus palatinus	$190.00
D7473	Removal of torus mandibularis	$190.00
D7485	Surgical reduction of osseous tuberosity	135.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$66.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$100.00
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$11.00
D7963	Frenuloplasty	$17.00

D8000-D8999 XI. ORTHODONTICS

- *The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.*
- *The Retention Copayment includes adjustments and/or office visits up to 24 months.*

Pre and post orthodontic records include:

	The benefit for pre-treatment records and diagnostic services includes:	$0.00
D0210	Intraoral - complete series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0351	3D photographic image	
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	$70.00
D0210	Intraoral - complete series of radiographic images	
D0470	Diagnostic casts	
D8050	Interceptive orthodontic treatment of the primary dentition	$2,739.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$2,739.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$2,774.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$2,774.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$3,590.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$61.00
D8670	Periodic orthodontic treatment visit	$0.00
D8680	Orthodontic retention (removal of appliances, construction and placement of removable retainers)	$345.00
D8681	Removable orthodontic retainer adjustment	$0.00
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session and records*	$175.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$45.00
D9219	Evaluation for deep sedation or general anesthesia	$0.00
D9223	Deep sedation/general anesthesia - each 15 minute increment	$73.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$73.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$0.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0.00
D9440	Office visit - after regularly scheduled hours	$70.00

D9450	Case presentation, detailed and extensive treatment planning	$0.00
D9932	Cleaning and inspection of removable complete denture, maxillary	$0.00
D9933	Cleaning and inspection of removable complete denture, mandibular	$0.00
D9934	Cleaning and inspection of removable partial denture, maxillary	$0.00
D9935	Cleaning and inspection of removable partial denture, mandibular	$0.00
D9940	Occlusal guard, by report - *limited to 1 in 24 months*	$255.00
D9943	Occlusal guard adjustment	$10.00
D9951	Occlusal adjustment, limited	$50.00
D9952	Occlusal adjustment, complete	$260.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$165.00

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned Contract Dentist, must be authorized by the Plan. The Enrollee pays the Copayment specified for such services. * Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" means the Contract Dentist's fees on file with the Plan. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

** Provisions regarding copayments and in and out-of-network treatment vary in Alaska, Connecticut, Idaho, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Carolina, Oklahoma, South Dakota and Vermont. See below.*

Alaska Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is $500.00. Enrollees are responsible for the copayments as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Connecticut Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. Copayments apply for in-network treatment only. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Contract Fee for a covered service with a calendar year maximum of $500.00. Enrollees are responsible for the other 50 percent plus the difference between the out-of-network Dentist's fee and the Contract Fee, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Idaho Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is $500.00. Enrollees are responsible for the copayments as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the DeltaCare USA network.

Louisiana, Mississippi and North Carolina Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan is the fee actually charged by the out-of-network Dentist or the Maximum Fee Allowance, whichever is lower, less the Copayment. If the out-of-network Dentist's fee is greater than the Maximum Fee Allowance, the enrollee is responsible for the difference as well as the copayment. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Maine, New Hampshire and Vermont Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit paid by the Plan for out-of-network treatment is 80 percent of the fee charged by the Dentist or 80 percent of the Maximum Fee Allowance, whichever is lower, less the copayment. Enrollees are responsible for the copayments as well as the other 20 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Montana Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for out-of-network treatment is 75 percent of the Maximum Fee Allowance for a covered service. Enrollees are responsible for the copayments as well as the other 25 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Oklahoma Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for out-of-network treatment is 70 percent of the Maximum Fee Allowance for a covered service. Enrollees are responsible for Copayments as well as the other 30 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

South Dakota Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is $500.00. Enrollees are responsible for the copayments, as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental Premier network.]

[SCHEDULE[AS1] B
LIMITATIONS AND EXCLUSIONS OF BENEFITS

Limitations

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $130 above the listed Copayment for each of these services after the sixth unit has been provided.

3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).

4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.

3. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.

4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers and crowns and fixed partial dentures (bridges).

6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

9. Consultations for non-covered benefits.

10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

12. Prescription drugs.

13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

14. Lost, stolen or broken orthodontic appliances.

15. Changes in orthodontic treatment necessitated by accident of any kind.

16. Myofunctional and parafunctional appliances and/or therapies.

17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.]

SERFF Tracking #:	*DDPA-130294232*	***State Tracking #:***		***Company Tracking #:***	*DC, DDIC, AMEX DC, FORM*

State:	*District of Columbia*	***Filing Company:***	*Delta Dental Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health Dental*		
Product Name:	*DC, DDIC, Amex dc, form*		
Project Name/Number:	*DC, DDIC, Amex dc, form/DC, DDIC, Amex dc, form*		

Supporting Document Schedules

Satisfied - Item:	Statement of Variability
Comments:	Please see the attached Statements of Variability.
Attachment(s):	S-A-D70-R16 Clean w Comments 101915.pdf S-B-D70 Clean w Comments 101915.pdf
Item Status:	FILED FOR INFORMATION ONLY/NO APPROVAL
Status Date:	11/02/2015

Satisfied - Item:	Previously Approved Forms
Comments:	The submitted Schedules will be used with the previously approved Contract and Evidence of Coverage. Attached are the Contract and EOC and the Department approval.
Attachment(s):	DeltaCare Contract.pdf DeltaCare EOC.pdf DeltaCare Approval.pdf
Item Status:	FILED FOR INFORMATION ONLY/NO APPROVAL
Status Date:	11/02/2015

Satisfied - Item:	Cover Letter
Comments:	Please see the attached Cover Letter.
Attachment(s):	Cover Letter.pdf
Item Status:	FILED FOR INFORMATION ONLY/NO APPROVAL
Status Date:	11/02/2015

[[AS1]**SCHEDULE A**
Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare USA Program and is not to be interpreted as CDT-2016 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	$0.00
D0140	Limited oral evaluation - problem focused	$0.00
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation - new or established patient	$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0.00
D0171	Re-evaluation - post-operative office visit	$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	$40.00
D0190	Screening of a patient	$0.00
D0191	Assessment of a patient	$0.00
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	$0.00
D0220	Intraoral - periapical first radiographic image	$0.00
D0230	Intraoral - periapical each additional radiographic image	$0.00
D0240	Intraoral - occlusal radiographic image	$0.00
D0270	Bitewing - single radiographic image	$0.00
D0272	Bitewings - two radiographic images	$0.00
D0273	Bitewings three radiographic images	$0.00
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	$0.00
D0277	Vertical bitewings - 7 to 8 radiographic images	$0.00
D0330	Panoramic radiographic image	$0.00
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50.00
D0460	Pulp vitality tests	$11.00
D0470	Diagnostic casts	$0.00
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0.00
D0601	Caries risk assessment and documentation, with a finding of low risk - *limited to children age 3 to 19, 1 every 3 years*	$0.00
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *limited to children age 3 to 19, 1 every 3 years*	$0.00
D0603	Caries risk assessment and documentation, with a finding of high risk - *limited to children age 3 to 19, 1 every 3 years*	$0.00
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	$0.00

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis cleaning - adult – *limited to 2 per calendar year*	$0.00
D1110	*Additional prophylaxis cleaning - adult (within the 12 month period)*	*$45.00*
D1120	Prophylaxis cleaning - child - *limited to 2 per calendar year*	$0.00
D1120	*Additional prophylaxis cleaning - child (within the 12 month period)*	*$30.00*
D1206	Topical application of fluoride varnish - *child to age 19; 2 D1206 or D1208 per calendar year*	$0.00
D1208	Topical application of fluoride - excluding varnish - *child to age 19; 2 D1206 or D1208 per calendar year*	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	$15.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	$15.00
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	$15.00
D1354	Interim caries arresting medicament application - *child to age 19; 2 per calendar year*	$0.00
D1510	Space maintainer - fixed - unilateral	$95.00
D1515	Space maintainer - fixed - bilateral	$155.00
D1555	Removal of fixed space maintainer	$0.00

D2000-D2999 III. RESTORATIVE

- *Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.*
- *When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $130.00 per crown, beyond the 6th unit.*
- *Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.*

D2140	Amalgam - one surface, primary or permanent	$16.00
D2150	Amalgam - two surfaces, primary or permanent	$21.00
D2160	Amalgam - three surfaces, primary or permanent	$26.00
D2161	Amalgam - four or more surfaces, primary or permanent	$32.00
D2330	Resin-based composite - one surface, anterior	$21.00
D2331	Resin-based composite - two surfaces, anterior	$26.00
D2332	Resin-based composite - three surfaces, anterior	$32.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$80.00
D2390	Resin-based composite crown, anterior	$105.00
D2391	Resin-based composite - one surface, posterior	$42.00
D2392	Resin-based composite - two surfaces, posterior	$53.00
D2393	Resin-based composite - three surfaces, posterior	$74.00
D2394	Resin-based composite - four or more surfaces, posterior	$100.00
D2510	Inlay - metallic - one surface	$410.00
D2520	Inlay - metallic - two surfaces	$410.00
D2530	Inlay - metallic - three or more surfaces	$410.00
D2542	Onlay - metallic - two surfaces	$470.00
D2543	Onlay - metallic - three surfaces	$470.00
D2544	Onlay - metallic - four or more surfaces	$470.00
D2740	Crown - porcelain/ceramic substrate	$505.00
D2750	Crown - porcelain fused to high noble metal	$460.00
D2751	Crown - porcelain fused to predominantly base metal	$405.00
D2752	Crown - porcelain fused to noble metal	$430.00
D2780	Crown - ¾ cast high noble metal	$460.00
D2781	Crown - ¾ cast predominantly base metal	$405.00
D2782	Crown - ¾ cast noble metal	$430.00
D2790	Crown - full cast high noble metal	$460.00
D2791	Crown - full cast predominantly base metal	$405.00
D2792	Crown - full cast noble metal	$430.00

D2794	Crown - titanium	$460.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$41.00
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$41.00
D2920	Re-cement or re-bond crown	$41.00
D2921	Reattachment of tooth fragment, incisal edge or cusp (anterior)	$80.00
D2929	Prefabricated porcelain/ceramic crown - primary tooth - anterior	$98.00
D2930	Prefabricated stainless steel crown - primary tooth	$98.00
D2931	Prefabricated stainless steel crown - permanent tooth	$98.00
D2932	Prefabricated resin crown - anterior primary tooth	$120.00
D2933	Prefabricated stainless steel crown with resin window - anterior primary tooth	$145.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$145.00
D2940	Protective restoration	$13.00
D2941	Interim therapeutic restoration - primary dentition	$13.00
D2949	Restorative foundation for an indirect restoration	$98.00
D2950	Core buildup, including any pins when required	$98.00
D2951	Pin retention - per tooth, in addition to restoration	$21.00
D2952	Post and core in addition to crown, indirectly fabricated - includes canal preparation	$155.00
D2954	Prefabricated post and core in addition to crown - base metal post; includes canal preparation	$130.00
D2960	Labial veneer (resin laminate) – chairside	$95.00
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	$15.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	$33.00
D3120	Pulp cap - indirect (excluding final restoration)	$33.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$78.00
D3221	Pulpal debridement, primary and permanent teeth	$78.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$78.00
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration)	$315.00
D3320	Root canal - endodontic therapy, bicuspid tooth (excluding final restoration)	$370.00
D3330	Root canal - endodontic therapy, molar (excluding final restoration)	$505.00
D3331	Treatment of root canal obstruction; non-surgical access	$135.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$135.00
D3333	Internal root repair of perforation defects	$135.00
D3346	Retreatment of previous root canal therapy - anterior	$420.00
D3347	Retreatment of previous root canal therapy - bicuspid	$475.00
D3348	Retreatment of previous root canal therapy - molar	$605.00
D3410	Apicoectomy - anterior	$375.00
D3421	Apicoectomy - bicuspid (first root)	$405.00
D3425	Apicoectomy - molar (first root)	$430.00
D3426	Apicoectomy (each additional root)	$145.00
D3427	Periradicular surgery without apicoectomy	$375.00
D3430	Retrograde filling - per root	$100.00

D4000-D4999 V. PERIODONTICS

- *Includes preoperative and postoperative evaluations and treatment under a local anesthetic.*

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$240.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$120.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$120.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$295.00

D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant $155.00
D4245 Apically positioned flap $295.00
D4249 Clinical crown lengthening - hard tissue $325.00
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant $595.00
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant $310.00
D4263 Bone replacement graft - first site in quadrant $290.00
D4264 Bone replacement graft - each additional site in quadrant $225.00
D4266 Guided tissue regeneration - resorbable barrier, per site $380.00
D4267 Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal) $430.00
D4270 Pedicle soft tissue graft procedure $395.00
D4275 Non-autogenous connective tissue graft (including recipient site and donor material), first tooth, implant or edentulous tooth position in graft $395.00
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant or edentulous tooth position in graft $395.00
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site $198.00
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site $237.00
D4341 Periodontal scaling and root planing - four or more teeth per quadrant
- limited to 4 quadrants during any 12 consecutive months $110.00
D4342 Periodontal scaling and root planing - one to three teeth per quadrant
- limited to 4 quadrants during any 12 consecutive months $61.00
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis
- limited to 1 treatment in any 12 consecutive months $83.00
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth $45.00
D4910 Periodontal maintenance - *limited to 2 per calendar year* $78.00
D4921 Gingival irrigation - per quadrant $0.00

D5000-D5899 VI. PROSTHODONTICS (removable)

- *For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.*
- *Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.*
- *Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.*

D5110 Complete denture - maxillary $550.00
D5120 Complete denture - mandibular $550.00
D5130 Immediate denture - maxillary $550.00
D5140 Immediate denture - mandibular $550.00
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) $410.00
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) $410.00
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) $640.00
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) $640.00
D5221 Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth) $410.00
D5222 Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth) $410.00

D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) $640.00
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) $640.00
D5225 Maxillary partial denture - flexible base (including any clasps, rests and teeth) $410.00
D5226 Mandibular partial denture - flexible base (including any clasps, rests and teeth) $410.00
D5410 Adjust complete denture - maxillary $33.00
D5411 Adjust complete denture - mandibular $33.00
D5421 Adjust partial denture - maxillary $33.00
D5422 Adjust partial denture - mandibular $33.00
D5510 Repair broken complete denture base $65.00
D5520 Replace missing or broken teeth - complete denture (each tooth) $65.00
D5610 Repair resin denture base $65.00
D5630 Repair or replace broken clasp - per tooth $82.00
D5640 Replace broken teeth - per tooth $65.00
D5650 Add tooth to existing partial denture $65.00
D5660 Add clasp to existing partial denture - per tooth $82.00
D5710 Rebase complete maxillary denture $195.00
D5711 Rebase complete mandibular denture $195.00
D5720 Rebase maxillary partial denture $195.00
D5721 Rebase mandibular partial denture $195.00
D5730 Reline complete maxillary denture (chairside) $115.00
D5731 Reline complete mandibular denture (chairside) $115.00
D5740 Reline maxillary partial denture (chairside) $115.00
D5741 Reline mandibular partial denture (chairside) $115.00
D5750 Reline complete maxillary denture (laboratory) $170.00
D5751 Reline complete mandibular denture (laboratory) $170.00
D5760 Reline maxillary partial denture (laboratory) $170.00
D5761 Reline mandibular partial denture (laboratory) $170.00
D5810 Interim complete denture (maxillary) $295.00
D5811 Interim complete denture (mandibular) $295.00
D5820 Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months* $235.00
D5821 Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months* $235.00

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- *When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $130.00 per unit, beyond the 6th unit.*
- *Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.*

D6210 Pontic - cast high noble metal $460.00
D6211 Pontic - cast predominantly base metal $405.00
D6212 Pontic - cast noble metal $430.00
D6214 Pontic – titanium $460.00
D6240 Pontic - porcelain fused to high noble metal $460.00
D6241 Pontic - porcelain fused to predominantly base metal $405.00
D6242 Pontic - porcelain fused to noble metal $430.00
D6245 Pontic - porcelain/ceramic $450.00
D6602 Retainer inlay - cast high noble metal, two surfaces $460.00

D6603	Retainer inlay - cast high noble metal, three or more surfaces	$460.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$405.00
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$405.00
D6606	Retainer inlay - cast noble metal, two surfaces	$430.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$430.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$460.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$460.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$405.00
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$405.00
D6614	Retainer onlay - cast noble metal, two surfaces	$430.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$430.00
D6624	Retainer inlay – titanium	$460.00
D6634	Retainer onlay – titanium	$460.00
D6740	Retainer crown - porcelain/ceramic	$505.00
D6750	Retainer crown - porcelain fused to high noble metal	$460.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$405.00
D6752	Retainer crown - porcelain fused to noble metal	$430.00
D6780	Retainer crown - ¾ cast high noble metal	$460.00
D6781	Retainer crown - ¾ cast predominantly base metal	$405.00
D6782	Retainer crown - ¾ cast noble metal	$430.00
D6790	Retainer crown - full cast high noble metal	$460.00
D6791	Retainer crown - full cast predominantly base metal	$405.00
D6792	Retainer crown - full cast noble metal	$430.00
D6794	Retainer crown – titanium	$460.00
D6930	Re-cement or re-bond fixed partial denture	$62.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- *Includes preoperative and postoperative evaluations and treatment under a local anesthetic.*

D7111	Extraction, coronal remnants - deciduous tooth	$50.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$50.00
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$100.00
D7220	Removal of impacted tooth - soft tissue	$110.00
D7230	Removal of impacted tooth - partially bony	$145.00
D7240	Removal of impacted tooth - completely bony	$220.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$220.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$100.00
D7251	Coronectomy - intentional partial tooth removal	$145.00
D7260	Oroantral fistula closure	$315.00
D7261	Primary closure of a sinus perforation	$315.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$155.00
D7280	Surgical access of an unerupted tooth	$185.00
D7283	Placement of device to facilitate eruption of impacted tooth	$44.00
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$155.00
D7286	Incisional biopsy of oral tissue - soft - does not include pathology laboratory procedures	$120.00
D7287	Exfoliative cytological sample collection	$67.00
D7288	Brush biopsy - transepithelial sample collection	$67.00
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$100.00
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50.00
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$135.00
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$66.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$170.00

D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm $170.00
D7471 Removal of lateral exostosis (maxilla or mandible) $190.00
D7472 Removal of torus palatinus $190.00
D7473 Removal of torus mandibularis $190.00
D7485 Surgical reduction of osseous tuberosity 135.00
D7510 Incision and drainage of abscess - intraoral soft tissue $66.00
D7511 Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) $100.00
D7960 Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure $11.00
D7963 Frenuloplasty $17.00

D8000-D8999 XI. ORTHODONTICS

- *The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.*
- *The Retention Copayment includes adjustments and/or office visits up to 24 months.*

Pre and post orthodontic records include:
The benefit for pre-treatment records and diagnostic services includes: $0.00
D0210 Intraoral - complete series of radiographic images
D0322 Tomographic survey
D0330 Panoramic radiographic image
D0340 2D cephalometric radiographic image - acquisition, measurement and analysis
D0350 2D oral/facial photographic images obtained intraorally or extraorally
D0351 3D photographic image
D0470 Diagnostic casts

The benefit for post-treatment records includes: $70.00
D0210 Intraoral - complete series of radiographic images
D0470 Diagnostic casts

D8050 Interceptive orthodontic treatment of the primary dentition $2,739.00
D8060 Interceptive orthodontic treatment of the transitional dentition $2,739.00
D8070 Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19* $2,774.00
D8080 Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19* $2,774.00
D8090 Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children* $3,590.00
D8660 Pre-orthodontic treatment examination to monitor growth and development $61.00
D8670 Periodic orthodontic treatment visit $0.00
D8680 Orthodontic retention (removal of appliances, construction and placement of removable retainers) $345.00
D8681 Removable orthodontic retainer adjustment $0.00
D8999 Unspecified orthodontic procedure, by report - *includes treatment planning session and records* $175.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110 Palliative (emergency) treatment of dental pain - minor procedure $45.00
D9219 Evaluation for deep sedation or general anesthesia $0.00
D9223 Deep sedation/general anesthesia - each 15 minute increment $73.00
D9243 Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment $73.00
D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician $0.00
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed $0.00
D9440 Office visit - after regularly scheduled hours $70.00

D9450	Case presentation, detailed and extensive treatment planning	$0.00
D9932	Cleaning and inspection of removable complete denture, maxillary	$0.00
D9933	Cleaning and inspection of removable complete denture, mandibular	$0.00
D9934	Cleaning and inspection of removable partial denture, maxillary	$0.00
D9935	Cleaning and inspection of removable partial denture, mandibular	$0.00
D9940	Occlusal guard, by report - *limited to 1 in 24 months*	$255.00
D9943	Occlusal guard adjustment	$10.00
D9951	Occlusal adjustment, limited	$50.00
D9952	Occlusal adjustment, complete	$260.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$165.00

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide specialized services, and are referred by the assigned Contract Dentist, must be authorized by the Plan. The Enrollee pays the Copayment specified for such services. * Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" means the Contract Dentist's fees on file with the Plan. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

** Provisions regarding copayments and in and out-of-network treatment vary in Alaska, Connecticut, Idaho, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Carolina, Oklahoma, South Dakota and Vermont. See below.*

Alaska Only:

In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is $500.00. Enrollees are responsible for the copayments as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Connecticut Only:

In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. Copayments apply for in-network treatment only. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Contract Fee for a covered service with a calendar year maximum of $500.00. Enrollees are responsible for the other 50 percent plus the difference between the out-of-network Dentist's fee and the Contract Fee, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Idaho Only:

In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is $500.00. Enrollees are responsible for the copayments as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the DeltaCare USA network.

Louisiana, Mississippi and North Carolina Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan is the fee actually charged by the out-of-network Dentist or the Maximum Fee Allowance, whichever is lower, less the Copayment. If the out-of-network Dentist's fee is greater than the Maximum Fee Allowance, the enrollee is responsible for the difference as well as the copayment. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing *deltadentalins.com* prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Maine, New Hampshire and Vermont Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit paid by the Plan for out-of-network treatment is 80 percent of the fee charged by the Dentist or 80 percent of the Maximum Fee Allowance, whichever is lower, less the copayment. Enrollees are responsible for the copayments as well as the other 20 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Montana Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for out-of-network treatment is 75 percent of the Maximum Fee Allowance for a covered service. Enrollees are responsible for the copayments as well as the other 25 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

Oklahoma Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for out-of-network treatment is 70 percent of the Maximum Fee Allowance for a covered service. Enrollees are responsible for Copayments as well as the other 30 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental PPO network.

South Dakota Only:
In accordance with state regulatory requirements, procedures listed above may also be performed by an out-of-network Dentist. The benefit amount paid by the Plan for out-of-network treatment is 50 percent of the Maximum Fee Allowance for a covered service, less the copayment. The calendar year maximum is $500.00. Enrollees are responsible for the copayments, as well as the other 50 percent plus the difference between the out-of-network Dentist's fee and the Maximum Fee Allowance, if any. An Enrollee should confirm a Dentist's participation in the DeltaCare USA network by accessing deltadentalins.com prior to seeking treatment. Or the Enrollee may contact the Customer Service department at 800-422-4234. An in-network Dentist is a Dentist who participates in the Delta Dental Premier network.]

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Main document changes and comments

Page 1: Comment [AS1]	**Ashley Singer**	**10/9/2015 9:47:00 AM**

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Endnote changes

[SCHEDULE[AS1] B
LIMITATIONS AND EXCLUSIONS OF BENEFITS

Limitations

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*

2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $130 above the listed Copayment for each of these services after the sixth unit has been provided.

3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).

4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon Authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.

5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.

6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments*.

2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.

3. Services solely for cosmetic purposes, with the exception of procedure D9975 (external bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.

4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.

5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers and crowns and fixed partial dentures (bridges).

6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).

7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.

8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

9. Consultations for non-covered benefits.

10. Dental services received from any dental facility other than the assigned Contract Dentist, an authorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.

11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

12. Prescription drugs.

13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

14. Lost, stolen or broken orthodontic appliances.

15. Changes in orthodontic treatment necessitated by accident of any kind.

16. Myofunctional and parafunctional appliances and/or therapies.

17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.]

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Main document changes and comments

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Endnote changes

DELTA DENTAL INSURANCE COMPANY
1000 Mansell Exchange West
Building 100, Suite 100
Alpharetta, Georgia 30022

APPLICATION FOR DeltaCare GROUP DENTAL SERVICE CONTRACT

The undersigned client ("Applicant") hereby applies for a DeltaCare GROUP DENTAL SERVICE CONTRACT with Delta Dental Insurance Company ("Delta") on the following terms:

I. Applicant hereby authorizes Delta to furnish the dental Benefits described in the attached Contract, subject to all of the terms and conditions of the Contract.

II. Applicant [or Enrollees] agree[s] to pay to Delta, in advance, the Premiums specified in *Schedule* [*C* or *F*] to the Contract. Applicant shall have a grace period of 31 days for Premium payment during which this Contract shall remain in force. Delta will furnish Benefits during a grace period and Applicant shall remain responsible for Premiums incurred during this period.

III. Upon acceptance of this Application by Delta, and payment of the initial Premiums, the Contract shall be effective at 12:01 a.m. on the Effective Date shown on *Schedule* [*C* or *F*] and the Contract shall continue until terminated as provided. Payment of Premiums constitutes acceptance of the terms and conditions of this Contract.

IV. Applicant agrees to receive, on behalf of Enrollees, all applicable notices concerning Benefits under this Contract.

V. Unless such task has been delegated to Delta, or to a third party, Applicant agrees to make available to Eligible Employees or Enrollees any disclosure statement or other notices concerning Benefits required to be furnished by Delta.

_____
(Date)

[1234]
(Group Number)

[Dental Applicant Company]
(Applicant)

[810 First Street, NE, Washington, DC 20002]
(Applicant Address)

By: _____ By: _____
(Authorized Signature) (Licensed Registered Agent)

DELTA DENTAL INSURANCE COMPANY
1000 Mansell Exchange West
Building 100, Suite 100
Alpharetta, Georgia 30022

DeltaCare GROUP DENTAL SERVICE CONTRACT

NOTICE: THE PREMIUMS PAYABLE UNDER THIS CONTRACT ARE SUBJECT TO INCREASE UPON RENEWAL AFTER THE END OF THE INITIAL CONTRACT TERM OR ANY SUBSEQUENT CONTRACT TERM.

IN CONSIDERATION of the Application, a copy of which is attached hereto and made a part of this DeltaCare GROUP DENTAL SERVICE CONTRACT ("Contract") and IN CONSIDERATION of payment of the required Premiums, DELTA DENTAL INSURANCE COMPANY ("Delta") agrees to provide the Benefits described for the Contract Term shown on *Schedule* [*C* or *F*] and from year to year thereafter, unless this Contract is terminated as provided. Premiums are payable in advance of the Effective Date and thereafter as provided. This Contract is issued and delivered in the District of Columbia, is governed by the laws thereof, and is subject to the terms and conditions recited on the following pages.

IN WITNESS WHEREOF, Delta has caused this Contract to be executed on:

Date: _____

DELTA DENTAL INSURANCE COMPANY

By: _____

TABLE OF CONTENTS

ARTICLE 1. DEFINITIONS

For the purpose of this Contract, the following definitions shall apply:

1.01 "Administrator" means Private Medical-Care, Inc. dba PMI Dental Health Plan ("PMI") a California corporation, operating as an Administrator in the District of Columbia. Administrative functions described throughout this Contract may be performed by PMI, as designated by Delta. The mailing address for PMI is 12898 Towne Center Drive, Cerritos, California 90703. PMI will answer calls directed to (800) 422-4234.

1.02 "Applicant" means the client (employer, or other organization) contracting to obtain dental Benefits for Eligible Employees.

1.03 "Benefits" mean those dental services which are provided under the terms of this Contract as specified in *Article 4* and *Schedule A*.

1.04 "Contract" means this agreement between Delta and Applicant including the Application for this Contract, the attached schedules, and any appendices, endorsements or riders. This Contract constitutes the entire agreement between the parties.

1.05 "Contract Dentist" means a Dentist who provides services in general dentistry and who agreed to provide Benefits to Enrollees under this Contract.

1.06 "Contract Orthodontist" means a Dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Contract.

1.07 "Contract Specialist" means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Contract.

1.08 "Contract Term" means the period commencing and terminating on the dates shown on *Schedule* [*C* or *F*], and each yearly period thereafter during which this Contract remains in effect.

1.09 "Copayment" means the amount charged to an Enrollee by a Dentist for the Benefits provided under this Contract.

1.10 "Dentist" means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

1.11 ["Domestic Partner" means a person who, together with the Eligible Employee, has affirmed a domestic partnership through an Affidavit of Domestic Partnership filed with Applicant.]

[1.12] "Effective Date" means the date this Contract becomes effective as provided in *Schedule* [*C or F]*.

[1.13] "Elective Procedures" mean alternative dental services that the Enrollee may elect in lieu of standard Benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.

[1.14] "Eligibility Date" means the date upon which an Eligible Person's eligibility for Benefits becomes effective under this Contract.

[1.15] "Eligible Dependent" means any of the dependents of an Eligible Employee who are eligible to enroll for Benefits and who meet the conditions of eligibility outlined in *Article 2*.

[1.16] "Eligible Employee" means any employee or member who meets the conditions of eligibility outlined in *Article 2*.

[1.17] "Eligible Person" means an Eligible Employee or Eligible Dependent.

[1.18] "Emergency Services" mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the patient's health in serious jeopardy.

[1.19] "Enrollee" means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

[1.20] "Full-Time Student" means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

[1.21] "Open Enrollment Period" means the period preceding the date of commencement of the Contract Term or the 30-day period immediately preceding the annual anniversary of the commencement of the Contract Term or a period as otherwise requested by the Applicant and agreed to by Delta.

[1.22] "Optional" means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of this Contract.

[1.23] "Preauthorization" means the process by which PMI determines if a procedure or treatment is a referable covered Benefit under the Enrollee's plan.

[1.24] "Premium" means payments by Applicant [or an Enrollee] as provided in *Article 3* and in amounts stated in *Schedule* [*C* or *F*].

[1.25] "Specialist Services" mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry and which must be preauthorized in writing by Delta.

ARTICLE 2. ELIGIBILITY, ENROLLMENT AND CANCELLATION OF ENROLLMENT

2.01 Eligible Employees are those employees or group members described in *Schedule* [*C or F*]. New employees shall become eligible for coverage as specified in *Schedule* [*C or F*].

Eligible Dependents become eligible on:

1) the date the Eligible Employee is eligible for coverage;

2) as soon as an Eligible Dependent becomes the dependent of an Eligible Employee, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:

1) spouse (unless legally separated or divorced) [or Domestic Partner (until such partnership is terminated by either or both parties)];

2) unmarried children from birth up to age [19 – 26];

3) unmarried children from [19 to age 26] if they are wholly dependent on the Eligible Employee for support and are Full-Time Students.

Children include natural children, stepchildren, adopted children, [and] foster children [and children of a Domestic Partner] provided all such children are dependent on the Eligible Employee for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible during and after the period of probation.

An unmarried dependent child may continue eligibility if:

a) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;

b) he or she is chiefly dependent on the Eligible Employee for support; and

c) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this Dependent reaches age [21]. Eligibility will continue as long as the dependent relies on the Eligible Employee for support because of a mental or physical disability that began before he or she reached the limiting age.

The dependent child is not required to reside with a parent or legal guardian who is an Enrollee.

Dependents in active military service are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect eligibility of an Eligible Employee or Eligible Dependent.

2.02 Eligible Employees must complete the enrollment process during the Open Enrollment Period in order to receive Benefits and for their Eligible Dependents to receive Benefits. Persons not originally eligible during the Open Enrollment Period may be enrolled immediately upon attainment of dependent status. Subject to cancellation as provided under this Contract, enrollment of Eligible Employees and any Eligible Dependents is for a minimum period of one year.

On or prior to the first day of every month, Applicant shall compile and furnish to Delta the names of all Primary Enrollees showing their [identification numbers] and, if applicable, location codes and all Dependent Enrollees. Enrollee names must be presented in a format acceptable to Delta. Delta shall be obligated to provide Benefits only to Primary Enrollees and their Dependent Enrollees who have

been reported by the Applicant. The appropriate Premium must be paid pursuant to *Article 3* and *Schedule* [*C* or *F*] of this Contract for the period in which covered dental services are provided.

2.03 Subject to any rights provided under *Article 9*, an Eligible Employee's or Eligible Dependent's enrollment under this Contract may be canceled, or renewal of enrollment refused, in the following events:

1) Immediately

   a) upon loss of eligibility as described in this Contract, or

   b) if an Enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;

2) Upon 15 days written notice if

   a) the Premiums are not paid by or on behalf of the Enrollee on the date due or within the 31 day Premium grace period. However the Enrollee may continue to receive Benefits during the 31-day period and may be reinstated during the term of this Contract upon payment of any unpaid Premium; or

   b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under this Contract;

3) Upon 30 days written notice if

   a) the Contract is terminated or not renewed;

   b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of this Contract upon payment of all delinquent charges; or

   c) a satisfactory patient-dentist relationship fails to be established with multiple contract facilities. PMI must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist.

      If the Enrollee establishes a history of unsatisfactory relationships, PMI will notify the Enrollee in writing, at least 30 days in advance, that PMI considers the patient-dentist relationships to be unsatisfactory. PMI will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes.

Cancellation of a Primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

ARTICLE 3. PREMIUMS AND COPAYMENTS

[3.01 In accordance with *Schedule* [*C* of *F*], Applicant agrees to pay Premiums on behalf of Primary Enrollees and Dependent Enrollees enrolled for Benefits under this Contract. Applicant shall remit one check each period as required by *Schedule* [*C* or *F]*. Should an Enrollee voluntarily cancel enrollment and subsequently desire to re-enroll, all Premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before the Enrollee shall be reenrolled.]

[3.01 In accordance with *Schedule* [*C* or *F*], Applicant agrees to pay Premiums on behalf of Primary Enrollees and to collect Premiums by means of payroll deductions for Dependent Enrollees voluntarily enrolled for Benefits under this Contract. Applicant shall remit one check each period as required by *Schedule* [*C* or *F*]. Should an Enrollee voluntarily cancel enrollment and subsequently desire to re-enroll, all Premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before the Enrollee shall be re-enrolled.]

[3.01 In accordance with *Schedule* [*C* or *F*], Applicant agrees to collect Premiums by means of payroll deductions for Primary Enrollees and Dependent Enrollees voluntarily enrolled for Benefits under this Contract. Applicant shall remit one check each period as required by *Schedule [C* or *F*]. Should an Enrollee voluntarily cancel enrollment and subsequently desire to re-enroll, all Premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before the Enrollee shall be re-enrolled.]

[3.01 In accordance with *Schedule* [*C* or *F*], Applicant agrees to collect Premiums by means of payroll deductions for Primary Enrollees and Dependent Enrollees voluntarily enrolled for Benefits under this Contract. Applicant shall remit one check each period as required by *Schedule* [*C* or *F*]. Premiums which are not payroll deducted shall be paid directly to PMI by Primary Enrollees as required by *Schedule* [*C* or *F*]. Should an Enrollee voluntarily cancel enrollment and subsequently desire to re-enroll, all Premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before the Enrollee shall be re-enrolled.]

3.02 This Contract shall not be in effect until initial Premiums are received. Benefits shall not be provided unless subsequent Premiums are received in accordance with this Contract.

3.03 Delta may change the amount of Premiums whenever the terms of this Contract are changed by amendment or Delta's liability is changed by law or regulation, provided the current Premiums have been in effect for a minimum of 12 months. However, in the absence of an amendment mutually agreed upon between Applicant and Delta or such a change in liability, no change in the Premiums shall become effective within a Contract Term except as provided in *Section 3.04*.

3.04 If during a Contract Term, any new tax is imposed on PMI by any government agency on the amount of Premiums payable under this Contract or the number of persons covered, or if the rate of an existing tax on the amount of Premiums or the number of persons covered is increased, the Premiums stated in *Schedule* [*C* or *F*] may be increased by the amount of any such new tax or increased taxes upon 30 days written notice.

3.05 Upon discovery of clerical errors made by the Administrator with respect to enrollment data for an Enrollee, Premiums may be adjusted back to the Enrollee's enrollment date.

3.06 Upon discovery of clerical errors made by the Applicant with respect to enrollment data, the amount of credit which may be taken with respect to an Enrollee shall not exceed the [Premiums for the current month in which Premiums are due, plus two months of retroactive Premiums]. In addition, the total amount of credit which may be taken on any due date shall not exceed [10% of the billed amount for that due date].

3.07 Enrollees are required to pay any Copayments listed in *Schedule A,* directly to the Dentist. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice) and charges for emergency visits after normal visiting hours are also shown on *Schedule A*.

3.08 In the event of cancellation of enrollment by Delta, Delta shall return to Applicant the pro rata portion of the Premiums paid to Delta which corresponds to any unexpired period for which payment had been received, together with any amounts due on claims, if any, less any amounts owed to Delta. This provision does not apply if the Enrollee engaged in fraud or deception in obtaining Benefits from PMI or knowingly permitted such fraud or deception by another.

ARTICLE 4. BENEFITS, LIMITATIONS AND EXCLUSIONS

4.01 Delta shall provide the Benefits in *Schedule A*, subject to the limitations and exclusions in *Schedule[s] B* [through *E]*. Benefits are available to each Enrollees on the Eligibility Date.

4.02 Delta shall provide Contract Dentists at convenient locations during the term of this Contract. A list of Contract Dentists shall be furnished to all Primary Enrollees. Enrollees may select any Contract Dentist whose name is on said list at the time of enrollment. Enrollees in the same family may collectively select no more than three Contract Dentist facilities. If an Enrollee fails to select a Contract Dentist or the Contract Dentist selected becomes unavailable, Delta shall request the selection of another Contract Dentist or shall assign that Enrollee to another Contract Dentist. An Enrollee may make a change to any other Contract Dentist during the Open Enrollment Period. Upon the approval of Delta, an Enrollee may select another Contract Dentist if the Enrollee has a change in family status or residence or fails to establish a satisfactory patient/doctor relationship with the Contract Dentist. The change must be requested prior to the 21st of the month to become effective on the first day of the following month.

[4.03 All services which are Benefits shall be rendered at the Contract Dentist's facility selected by the Enrollee. Delta shall have no obligation or liability with respect to services rendered by out-of network Dentists, with the exception of Emergency Services as provided in *Section 4.04*, or Specialist Services recommended by a Contract Dentist, and preauthorized in writing by Delta. All preauthorized Specialist Services claims will be paid by Delta less any applicable Copayments. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.]

[4.03 All services which are Benefits shall be rendered at the facility of a Contract Dentist selected by the Enrollee or a Contract Specialist, upon referral by the Contract Dentist. Delta relies on the professional judgment of the general Dentist to diagnose the appropriate efficient and prudent solution to the Enrollee's dental needs based on the plan Benefits. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services. Delta shall have no obligation or liability with respect to services rendered by out-of-network Dentists, with the exception of Emergency Services as provided in *Section 4.04*. The Enrollee will pay all Specialist Services, which are Benefits, directly to the Contract Specialist. If there is not an available Contract Specialist in the area, there are no Benefits for Specialist Services].

4.04 The Enrollee should contact the assigned Contract Dentist for Emergency Services for covered dental procedures whenever possible. If the Enrollee is unable to reach their Contract Dentist for Emergency Services, the Enrollee should call Customer Relations at (800) 422-4234 for assistance in obtaining urgent care. During non-business hours or if the Enrollee requires Emergency Services and is 35 miles or more from his or her assigned Contract Dentist, the Enrollee does not need to call for referral and may seek treatment from a Dentist other than their assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of [$50.00 - $100.00] [during any 12-month period] [per 12 calendar months]. The Enrollee is responsible for the Copayment(s) as well as any charges over the [$50.00 - $100.00] benefit maximum. Emergency dental care shall be limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

4.05 Claims for covered Emergency Services [or preauthorized Specialist Services] must be sent within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if the Enrollee can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date.

4.06 In the event Delta fails to pay a Contract Dentist [or Contract Specialist], the Enrollee will not be liable to that Dentist for any sums owed by Delta.

[Except for provisions in *Article 4.04,* if the Enrollee has not received Preauthorization for treatment from an out-of-network Dentist, and Delta fails to pay that out-of-network Dentist, the Enrollee will be liable to that Dentist for the cost of services.]

[Except for provisions in *Article 4.04,* Delta will not pay a Dentist who is not a Contract Dentist; therefore, if the Enrollee receives treatment from an out-of-network Dentist, the Enrollee will be liable to that Dentist for the cost of services.]

4.07 Upon termination of a Contract Dentist's agreement, Delta shall be liable for Benefits for the completion of treatment for single procedures begun prior to the termination of the agreement. The terminating Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

If for any reason the Contract Dentist is unable to complete treatment, Delta shall make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist.

4.08 In the absence of an amendment mutually agreed upon between Applicant and Delta, no change in Benefits shall be made during a Contract Term.

4.09 All Benefits shall terminate for any Enrollee as of the date that this Contract is terminated, such person ceases to be eligible under the terms of this Contract, or such person's enrollment is cancelled under this Contract. Delta shall not be obligated to continue to provide Benefits to any such person in such event, except for completion of single procedures commenced while this Contract was in effect.

ARTICLE 5. COORDINATION OF BENEFITS

5.01 This Contract provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Contract by [specialists or] out-of-network Dentists are coordinated with such other group dental insurance policy or any group dental benefits program.

5.02 When Benefits are coordinated with another group insurance policy or group health benefits program, the determination of which policy or program is primary shall be governed by the following rules:

a) The policy or program covering the Enrollee as other than a dependent shall be primary over the policy or program covering the Enrollee as a dependent.

b) The policy or program covering a child as a dependent of a parent whose birthday occurs earlier in a calendar year shall be primary over the policy or program covering a child as a dependent of a parent whose birthday occurs later in a calendar year (except for a dependent child whose parents are separated or divorced as described in c) below). If both parents have the same birthday, the plan that covered either of the parents longer is primary.

c) In the case of a dependent child whose parents are legally separated or divorced:

1) If the parent with custody has not remarried, the policy or program covering the child as a dependent of the parent with custody shall be primary over the policy or program covering the child as a dependent of the parent without custody.

2) If the parent with custody has remarried, the policy or program covering the child as a dependent of the parent with custody shall be primary over the policy or program covering the child as a dependent of the step-parent, and the policy or program covering the child as a dependent of the step-parent shall be primary over the policy or program covering the child as a dependent of the parent without custody.

3) If there is a court decree that establishes financial responsibility for dental services which are Benefits under this program, and if the plan with responsibility for payment has actual knowledge of the existence of the court decree, notwithstanding c) 1) and 2), the policy or program covering the child as a dependent of the parent with such financial responsibility shall be primary over any other policy or program covering the child.

d) If the primary policy or program cannot be determined by the rules described in a), b) or c), the policy or program which has covered the Enrollee for a longer period of time shall be primary, with the following exception: A policy or program covering the Enrollee as a laid-off or retired employee or the dependent of a laid-off or retired employee shall not be primary under this rule d) over a policy or program covering the Enrollee as an employee or the dependent of an employee. However, if the provisions of the other policy or program do not include this exception, which results in benefits under neither being primary, then this exception shall not apply.

5.03 When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses.

"Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

5.04 An Enrollee shall provide to Delta, and Delta may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under these coordination of benefits provisions, and any such reimbursement paid shall be deemed to be Benefits under this Contract. Delta shall have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta chooses, the amount of any Benefits paid by Delta which exceed its obligations under these coordination of benefit provisions.

ARTICLE 6. ENROLLEE COMPLAINT PROCEDURE

6.01 Delta or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If an Enrollee has any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta or the Administrator or the quality of dental services performed by a Contract Dentist, he or she may call the Customer Relations department at (800) 422 4234, or the complaint may be addressed in writing to:

Quality Management Department
MS: QM600
12898 Towne Center Drive
Cerritos, California 90703-8579

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Applicant and 4) the Dentist's name and facility location.

6.02 For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) the Enrollee must file a request for review (a complaint) with Delta within 180 days after receipt of the adverse determination. Delta's review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, Delta will provide the Enrollee with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If any consulting dentist is involved in the review, the identity of such consulting dentist will be available upon request.

6.03 Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to the complainant an acknowledgment of receipt of the complaint. Certain complaints may require that the complainant be referred to a Dentist for a clinical evaluation of the dental services provided. Delta will make a determination, in writing, within 30 days of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. Delta shall undertake a full and fair review upon request. Delta may require additional documents, as it deems necessary in making such a review. Delta shall provide a written response to the complainant within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

6.04 If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Enrollee may contact the U.S. Department of Labor, Employee Benefits Security Administration for further review of the claim or if the Enrollee has questions about the rights under ERISA. The Enrollee may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

ARTICLE 7. GENERAL PROVISIONS

7.01 The Contract, the Contract application, and any attached schedules, appendices, endorsements and riders, constitute the entire agreement between Delta and Applicant. No agent has authority to amend this Contract or waive any of its provisions. No amendment to this Contract shall be valid unless approved by an executive officer of Delta and evidenced by endorsements.

7.02 If any portion of this Contract or any amendment thereof shall be determined by any arbitrator, court or other competent authority to be illegal, void or unenforceable, such determination shall not abrogate this Contract or any portion thereof other than such portion determined to be illegal, void or unenforceable, and all other portions of this Contract shall remain in full force and effect.

7.03 The parties agree that all questions regarding interpretation or enforcement of this Contract shall be governed by the laws of the District of Columbia, where the Contract was entered into and is to be performed. Delta Dental Insurance Company is licensed as a Group Accident and Health Insurer in the District of Columbia and is subject to the provisions of Title 35 of the District of Columbia Insurance Laws. Any provisions required to be in the Contract by the above shall bind Delta whether or not provided in this Contract.

7.04 Unless this task has been delegated to the Applicant or a third party, Delta will issue to each Primary Enrollee an evidence of coverage summarizing the Benefits to which each Enrollee is entitled. If any amendment to this Contract shall materially affect any provisions described in such evidence of coverage, new evidence of coverage booklets or riders showing the change shall be issued. Any direct conflict between the evidence of coverage and this Contract shall be resolved according to the terms most favorable to the Enrollee.

7.05 Both parties to this Contract agree to consult to the extent reasonably practical concerning all material published or distributed relating to this Contract. No such material shall be published or distributed which is contrary to the terms of this Contract.

7.06 Applicant shall designate in writing a representative for purposes of receiving notices from Delta under this Contract. Applicant may change its representative at any time on 30 days notice to Delta. Any notice under this Contract shall be sufficient if given by either Applicant or Delta to the other addressed as stated on the Application of this Contract, and shall be effective 48 hours after deposit in the United States mail with postage fully prepaid. Any notice required from Delta to any Enrollee may be given to Applicant's representative, who shall disseminate such notice to Enrollees by next regular communication but in no event later than 30 days after receipt thereof.

7.07 Delta shall be excused from performance under this Contract for any period and to the extent that it is prevented from performing any services in whole or in part as a result of an act of God, war, civil disturbance, court order, or other cause beyond its reasonable control and which it could not have been prevented by reasonable precautions.

7.08 Both parties to this Contract shall comply in all respects with all applicable federal, state and local laws and regulations relating to administrative simplification, security, and privacy of individually identifiable Enrollee information. Both parties agree that this Contract may be amended as necessary to comply with federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 or to comply with any other enacted administrative simplification, security or privacy laws or regulations.

ARTICLE 8. TERMINATION AND RENEWAL

8.01 This Contract may be terminated by Delta upon Applicant's failure (i) to furnish Delta with the names of eligible Enrollees as required by *Article 2*, or (ii) to pay Premiums in the amount and manner required by *Article 3*, provided Applicant has been notified of such failure subsequent to a 31 day Premium grace period and at least 15 days have elapsed since such notification.

8.02 PMI may terminate this Contract upon [30] days written notice in the event the minimum enrollment of five Primary Enrollees is not maintained in three consecutive months at any time during a Contract Term.

8.03 Termination at the end of a Contract Term, for any reason, shall be by at least [30-210] days advance written notice of termination by certified mail given by the party desiring to terminate to the other party.

In the event that Delta shall desire to change Premiums or Benefits effective at the end of any Contract Term, and Premiums and Benefits have been if effect for at least 12 months, advice of such changes will be given to Applicant upon at least [30-210] days written notice. Such notice shall renew the Contract for another Contract Term at the rates and with the coverage as stated in the notice unless Applicant provides written notification to Delta by certified mail on or before the date stated in the notice that Applicant does not choose to renew.

8.04 Acceptance by Delta of the proper Premiums after termination of this Contract and without requiring a new application, shall reinstate this Contract as though it had never terminated, unless Delta shall, within 20 business days of receipt of such payment, either 1) refuse the payment so made, or 2) issue to Applicant a new Contract accompanied by written notice stating clearly those respects in which the new Contract differs from this terminated Contract in Benefits, coverage or otherwise.

8.05 This Contract will terminate at midnight of the last day of the period for which Applicant has paid Premium to Delta, except as provided in the grace period below:

Grace Period: This Contract has a 31-day grace period. This provision means that, if any required Premium is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, the Contract will stay in force.

ARTICLE 9. OPTIONAL CONTINUATION OF COVERAGE

9.01 The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." Enrollees may be entitled to continue coverage under this plan, *at the Qualified Beneficiary's expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

9.02 DEFINITIONS

The meaning of key terms used in this section are shown below.

Qualified Beneficiary means:

1. Enrollees who are enrolled in the DeltaCare plan on the day before the Qualifying Event, or

2. a child who is born to or placed for adoption with the Primary Enrollee during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1: The termination of employment (other than termination for gross misconduct), or the reduction in work hours, by the Primary Enrollee's employer;

Event 2: The death of the Primary Enrollee;

Event 3: Divorce or legal separation from the Primary Enrollee;

Event 4: A dependent child ceasing to meet the description of dependent child;

Event 5: As to dependents only, a Primary Enrollee becoming entitled to Medicare.

9.03 PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the occurrence of Qualifying Event 1.

This 18 month period can be extended for a total of 29 months, provided:

1. a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or became disabled at any time during the first 60 days of continued coverage; and
2. notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. The Primary Enrollee must notify the employer within 30 days of any such determination.

If, during the 18 month continuation period resulting from Qualifying Event 1, the Primary Enrollee's dependents experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

The Primary Enrollee's dependents may continue coverage for 36 months following the month in which Qualifying Events 2, 3, 4 or 5 occur.

Under federal COBRA law, when an employer has filed for bankruptcy under Title II, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after the filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

9.04 ELECTION OF CONTINUED COVERAGE

The Primary Enrollee's employer shall notify Delta in writing within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4, or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly Premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give the employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer within 60 days will result in the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continued coverage, and any premiums received after that date will be returned to the Qualified Beneficiary.

9.05 CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

9.06 TERMINATION OF COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1. the allowable number of consecutive months of continued coverage is reached;

2. failure to pay the required Premium in a timely manner;

3. the employer ceases to provide any group dental plan to its employees;

4. the individual moves out of the plan's service area;

5. the individual first obtains coverage for dental benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such person, if that pre-existing condition is covered under this plan;

6. entitlement to Medicare.

The employer or Primary Enrollee shall notify Delta within 30 days of the occurrence of any of the above events. Once continued coverage terminates, it cannot be reinstated.

9.07 TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary (either 30 days prior to the termination or when all Enrollees are notified whichever is later) of that person's ability to elect continuation coverage under the employer's subsequent dental plan, if any. The employer must notify the successor plan of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage under that plan.

The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the DeltaCare program had such program with the former employer not terminated. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premium to the new group benefit plan within 30 days of receiving notice of the termination of the DeltaCare program.

9.08 OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the DeltaCare program.

ARTICLE 10. ATTACHMENTS

The following schedules are a part of this Contract:

Schedule A - Description of Benefits and Copayments

Schedule B - Limitations and Exclusions of Benefits

Schedule C - Group Variables and Premiums

Standard CDT4 Plans

or

Schedule B - Limitations of Benefits

Schedule C - Exclusions of Benefits

Schedule D - Orthodontic Limitations

Schedule E - Orthodontic Exclusions

Schedule F - Group Variables and Premiums

DeltaCare USA

SCHEDULE [C or F]

GROUP VARIABLES AND PREMIUMS

A. Client Name: [Dental Applicant Company]

B. Group Number: [1234]

C. Effective Date: [January 1, 2003]

D. Contract Term: [1 year]

E. Eligible Present Employees: [All active full-time employees]

Eligible New Employees: [All active full-time employees who have completed six consecutive months of employment.]

F. [Premiums per Month:

Plan Type: [DCA01]	
[Washington DC] Primary Enrollee:	$XX.XX
[Washington DC] Primary Enrollee Plus One Dependent Enrollee:	$YY.YY
[Washington DC] Primary Enrollee Plus Two or More Dependent Enrollees:	$ZZ.ZZ
Composite:	$QQ.QQ]

G. Remit Premium Payment to: [PMI, Dept. #0170 Los Angeles, California 90084-0170]

Dental Health Care Program
for Eligible Employees
and Dependents

Plan DCEOC

Combined Evidence of Coverage and Disclosure Form

Provided by:

Delta Dental Insurance Company
1000 Mansell Exchange West
Building 100, Suite 100
Alpharetta, Georgia 30022

Administered by:

Private Medical Care, Inc.
12898 Towne Center Drive
Cerritos, Ca 90703
(800) 422-4234
www.deltadentalca.org/pmi

EVIDENCE OF COVERAGE
DISCLOSURE FORM

DeltaCare Dental Health Care Program

This booklet is a Combined Evidence of Coverage and Disclosure Form ("EOC") for your DeltaCare Dental Health Care Program ("Program") provided by Delta Dental Insurance Company ("Delta"). The Program has been established and is administered in accordance with the provisions of a Group Dental Service Contract ("Contract") issued by Delta.

THE EOC CONSTITUTES ONLY A SUMMARY OF THE PROGRAM. THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF THE COVERAGE PROVIDED UNDER IT.

A COPY OF THE CONTRACT WILL BE FURNISHED UPON REQUEST. ANY DIRECT CONFLICT BETWEEN THE CONTRACT AND THE EOC WILL BE RESOLVED ACCORDING TO THE TERMS WHICH ARE MOST FAVORABLE TO YOU. READ THIS EOC CAREFULLY AND COMPLETELY.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM, OR WHAT GROUP OF PROVIDERS, DENTAL TREATMENT MAY BE OBTAINED.

The telephone number where you may obtain information about Benefits is (800) 422-4234.

Table of Contents

Definitions
As used in this booklet:

ADMINISTRATOR means Private Medical-Care, Inc. dba PMI Dental Health Plan ("PMI") a California corporation, operating as an Administrator in the District of Columbia. Administrative functions described throughout this Contract may be performed by PMI, as designated by Delta. The mailing address for PMI is 12898 Towne Center Drive, Cerritos, California 90703. PMI will answer calls directed to (800) 422-4234.

BENEFITS mean those dental services which are provided under the terms of the Group Dental Service Contract and described in this booklet.

CLIENT means the applicant (employer or other organization) contracting to obtain Benefits for Eligible Employees.

CONTRACT DENTIST means a Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees under this Program.

CONTRACT ORTHODONTIST means a dentist who specializes in orthodontics, and who has agreed to provide Benefits to Enrollees under this Program.

CONTRACT SPECIALIST means a Dentist who provides Specialist Services and has agreed to provide Benefits to Enrollees under this Program.

COPAYMENT means the amount charged to an Enrollee by a Contract Dentist for the Benefits provided under this Program.

DENTIST means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

[**DOMESTIC PARTNER** means a person who has, together with the Eligible Employee, affirmed a domestic partnership through an affidavit of Domestic Partnership filed with the Client.]

ELECTIVE PROCEDURE means alternative dental services that the Enrollee may elect in lieu of standard benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.

ELIGIBLE DEPENDENT means any dependent of an Eligible Employee who is eligible for Benefits as described in this booklet.

ELIGIBLE EMPLOYEE means any employee or group member who is eligible for Benefits as described in this booklet.

EMERGENCY SERVICES mean only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the patient's health in serious jeopardy.

ENROLLEE means an Eligible Employee ("Primary Enrollee") or an Eligible Dependent ("Dependent Enrollee") enrolled to receive Benefits.

FULL-TIME STUDENT means a student who is regularly attending an accredited school with an academic schedule of at least 12 credits.

OPEN ENROLLMENT PERIOD means the period preceding the date of commencement of the contract term or the 30-day period immediately preceding the annual anniversary of the contract term.

OPTIONAL means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the limitations and exclusions of the Contract.

PREAUTHORIZATION means the process by which Delta determines if a procedure or treatment is a referable covered Benefit under the Enrollee's plan.

SPECIALIST SERVICES mean services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry, and which must be preauthorized in writing by the Administrator.

WE, US or OUR means Delta or the Administrator as appropriate.

Eligibility for Benefits
Eligible Employees and Eligible Dependents receive Benefits as soon as they are enrolled in the Program. Subject to cancellation as provided under this Program, enrollment of Eligible Employees and Eligible Dependents is for a minimum period of one year.

You are eligible to enroll as an Eligible Employee if you meet the eligibility requirements defined by the Client.

Eligible Dependents become eligible on:

1) the date you are eligible for coverage;

2) as soon as an Eligible Dependent becomes your dependent, or at any time subject to a change in legal custody or lawful order to provide Benefits.

Eligible Dependents include:

1) spouse (unless legally separated or divorced) [or Domestic Partner (until such partnership is terminated by either or both parties)];

2) unmarried children from birth up to the limiting age as defined by the Client;

3) unmarried children beyond the limiting age if they are wholly dependent on you for support and are Full-Time Students.

Children include natural children, stepchildren, adopted children, [and] foster children [and children of a Domestic Partner] provided all such children are dependent on you for support. Newborn children (including newborn adopted children) are covered from and after the moment of birth. Notice of birth must be received within 31 days after the date of birth for coverage to continue beyond 31 days. Legally adopted children (other than newborns) are eligible during and after the period of probation.

An unmarried dependent child may continue eligibility if:

a) he or she is incapable of self-support because of a mental or physical disability that began prior to reaching the limiting age;

b) he or she is chiefly dependent on you for support; and

c) proof of dependent's disability is provided within 31 days of request. Such requests will not be made more than once a year after this Dependent reaches the limiting age. Eligibility will continue as long as the dependent relies on you for support because of a mental or physical disability that began before he or she reached the limiting age.

The dependent child is not required to reside with a parent or legal guardian who is an Enrollee.

Dependents in active military service are not eligible. No Eligible Dependent may be enrolled under more than one Eligible Employee. Medicare eligibility shall not affect the eligibility of an Eligible Employee or an Eligible Dependent.

Premiums
This Program requires premiums to be paid to Delta. If you are required to pay all or any portion of the premiums, you will be advised of the amount prior to enrollment and it will be deducted from your earnings by payroll deduction or you will be requested to pay it directly to Delta. The Client will be responsible for sending all payments of premiums to Delta except payments you are requested to pay directly. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll.

How to use the DeltaCare Program –
Choice of Contract Dentist

To enroll in this Program, you must select a Contract Dentist for both yourself and any Dependent Enrollee from the list of Contract Dentists furnished during the enrollment process. Collectively, you and your Eligible Dependents may select no more than three Contract Dentist facilities. If you fail to select a Contract Dentist or the Contract Dentist selected becomes unavailable, Delta will request the selection of another Contract Dentist or assign you to a Contract Dentist. While it is our preference that changes in Contract Dentists be made during the Open Enrollment Period only, a transfer to another location will be allowed upon request directed to us if you are not satisfied with the contract facility selected or have a change in family status or residence. In order to ensure that your Contract Dentist is notified and our eligibility lists are correct, changes in Contract Dentists must be requested prior to the 21st of the month for changes to be effective the first day of the following month.

Shortly after enrollment you will receive a membership packet that tells you the effective date of your Program and the address and telephone number of your Contract Dentist. After the effective date in your membership packet, you may obtain dental services which are Benefits. To make an appointment simply call your Contract Dentist's facility and identify yourself as a DeltaCare Enrollee. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquires regarding availability of appointments and accessibility of Dentists should be directed to the Customer Relations department at (800) 422-4234.

EACH ENROLLEE MUST GO TO HIS OR HER ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES, EXCEPT FOR [SERVICES PROVIDED BY A SPECIALIST PREAUTHORIZED IN WRITING BY THE ADMINISTRATOR] [SERVICES PROVIDED BY A CONTRACT SPECIALIST], OR FOR EMERGENCY SERVICES REQUIRED WHILE 35 MILES OR MORE FROM THE CONTRACT DENTIST'S FACILITY. ANY OTHER TREATMENT IS NOT COVERED UNDER THIS PROGRAM.

If your assigned Contract Dentist's agreement with Delta terminates, that Contract Dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

Benefits, Limitations and Exclusions

This Program provides the Benefits described in the *Description of Benefits and Copayments* subject to the limitations and exclusions. The services are performed as deemed appropriate by your attending Contract Dentist. A Contract Dentist may provide services either personally or through associated dentists, technicians or hygienists who may lawfully perform the services.

Copayments and Other Charges

You are required to pay any Copayments listed in the *Description of Benefits and Copayments* directly to the Dentist who provides treatment. Charges for broken appointments (unless notice is received by the Dentist at least 24 hours in advance or an emergency prevented such notice), and charges for visits after normal visiting hours are listed in the *Description of Benefits and Copayments*.

Emergency Services

You should contact your assigned Contract Dentist for Emergency Services whenever possible. If you are unable to reach your Contract Dentist for Emergency Services, you should call Customer Relations at (800) 422-4234 for assistance in obtaining urgent care. During non-business hours or if you are 35 miles or more from your assigned Contract Dentist, you do not need a referral and may seek treatment from a Dentist other than your assigned Contract Dentist.

Benefits for emergency treatment received from any Dentist, other than the assigned Contract Dentist, are limited to a maximum of [$50.00 - $100.00] [during any 12 month period] [per 12 calendar months], per Enrollee. You are responsible for the Copayment(s) as well as any charges over the [$50.00 - $100.00] benefit maximum.

Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist.

Specialist Services
[Specialist Services must be referred by the assigned Contract Dentist and preauthorized in writing by the Administrator. All preauthorized Specialist Services will be paid by us less any applicable Copayments.]

[Specialist Services must be referred by the assigned Contract Dentist. The Enrollee will pay for all Specialist Services, which are Benefits provided by a Contract Specialist, directly to the Contract Specialist. If there is not an available Contract Specialist in the area, there are no Benefits for Specialist Services.]

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the *Description of Benefits and Copayments*, and *Orthodontic Limitations and Exclusions* to determine which procedures are covered under this program.

Claims for Reimbursement
Claims for covered Emergency Services [or preauthorized Specialist Services] must be submitted to the Administrator within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. The address for claims submission is PMI Dental Health Plan, 12898 Towne Center Drive, Cerritos, CA 90703.

In the event that we fail to pay a Contract Dentist [or Contract Specialist], you will not be liable to that Dentist for any sums owed by us. [Except for the provisions in *Emergency Services,* if you have not received Preauthorization for treatment from an out-of-network Dentist, and we fail to pay that out-of-network Dentist, you may be liable to that Dentist for the cost of services.]

[Except for provisions in *Emergency Services*, we will not pay a Dentist who is not a Contact Dentist, therefore, if you have received treatment from an out-of-network Dentist, you will be liable to that Dentist for the cost of services.]

Coordination of Benefits
This Program provides Benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, Benefits provided under this Program by [specialists or] out-of-network Dentists are coordinated with any similar benefits provided by any other group dental insurance policy or any group dental benefits program. The determination of which policy or program is primary shall be governed by the rules stated in the Contract.

When this plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total Allowable Expenses. "Allowable Expense" is defined as a service or expense, including deductibles and Copayments, that is covered at least in part by any of the plans covering the person.

An Enrollee must provide to Delta and Delta may release to or obtain from any insurance company or other organization, any information about the Enrollee that is needed to administer coordination of benefits. Delta will, in its sole discretion, determine whether any reimbursement to an insurance company or other organizations is warranted under these coordination of benefits provisions, and any such reimbursement will be deemed to be Benefits under this Program. Delta will have the right to recover from a Dentist, Enrollee, insurance company or other organization, as Delta chooses, the amount of any Benefit paid by Delta which exceeds its obligations under these coordination of benefit provisions.

Enrollee Complaint Procedure

Delta or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta or the Administrator or the quality of dental services performed by a Contract Dentist, you may call the Customer Relations department at (800) 422 4234, or the complaint may be addressed in writing to:

Quality Management Department
MS: QM600
12898 Towne Center Drive
Cerritos, California 90703-8579

Written communication must include 1) the name of the patient, 2) the name, address, telephone number and identification number of the Primary Enrollee, 3) the name of the Applicant and 4) the Dentist's name and facility location.

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) you must file a request for review (a complaint) with Delta within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide you with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If any consulting dentist is involved in the review, the identity of such consulting dentist will be available upon request.

Within 10 business days of the receipt of any complaint, including adverse benefit determinations as described above, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a Dentist for a clinical evaluation of the dental services provided. We will make a determination, in writing, within 30 days of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint. A review of the decision shall be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. We shall undertake a full and fair review upon request. We may require additional documents, as it deems necessary in making such a review. We shall provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S.

Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Renewal and Termination of Benefits
This Program renews on the anniversary of the contract term unless we provide notice of a change in premiums or Benefits and the Client does not accept the change. All Benefits terminate for any Enrollee as of the date that this Program is terminated, such person ceases to be eligible under the terms of this Program, or such person's enrollment is cancelled under the terms of this Program. We are not obligated to continue to provide Benefits to any such person in such event except for completion of single procedures commenced while this Program was in effect.

Cancellation of Enrollment
Subject to any continued coverage option, an Eligible Employee's or Eligible Dependent's enrollment under the Program may be cancelled, or renewal of enrollment refused, in the following events:

1) Immediately
    a) upon loss of eligibility as described in this Evidence of Coverage, or
    b) if an enrollee engages in conduct detrimental to safe operations and the delivery of services while in a Contract Dentist's facility;
2) Upon 15 days written notice if
    a) the premiums are not paid by or on behalf of the Enrollee on the date due. However the Enrollee may continue to receive Benefits during the 15-day period and may be reinstated during the term of this Program upon payment of any unpaid Premium; or
    b) the Enrollee knowingly commits or permits another person to commit fraud or deception in obtaining Benefits under the Program;
3) Upon 30 days written notice if
    a) the Contract is terminated or not renewed;
    b) the Enrollee fails to pay Copayments. However, the Enrollee may be reinstated during the term of this Program upon payment of all delinquent charges; or
    c) a satisfactory dentist-patient relationship fails to be established with multiple contract facilities. Delta must show that it has, in good faith, provided the Enrollee with the opportunity to select an alternative Contract Dentist. If the Enrollee establishes a history of unsatisfactory relationships, Delta will notify the Enrollee in writing, at least 30 days in advance, that Delta considers the patient-dentist relationships to be unsatisfactory. Delta will also specify the changes that are necessary in order to avoid cancellation, and show that the Enrollee failed to make these changes;

Cancellation of a primary Enrollee's enrollment shall automatically cancel the enrollment of any of his or her Dependent Enrollees.

[Optional Continuation of Coverage
The federal Consolidated Omnibus Budget Reconciliation Act (or COBRA, pertaining to certain employers having 20 or more employees) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." Enrollees may be entitled to continue coverage under this plan, *at the Qualified Beneficiary's expense*, if certain conditions are met. The period of continued coverage depends on the Qualifying Event.

DEFINITIONS

The meaning of key terms used in this section are shown below.

Qualified Beneficiary means:

1. Enrollees who are enrolled in the DeltaCare plan on the day before the Qualifying Event, or
2. a child who is born to or placed for adoption with the Primary Enrollee during the period of continued coverage, provided such child is enrolled within 30 days of birth or placement for adoption.

Qualifying Event means any of the following events which, except for the election of this continued coverage, would result in a loss of coverage under the dental plan:

Event 1: The termination of employment (other than termination for gross misconduct), or the reduction in work hours, by the Primary Enrollee's employer;

Event 2: The death of the Primary Enrollee;

Event 3: Divorce or legal separation from the Primary Enrollee;

Event 4: A dependent child ceasing to meet the description of dependent child;

Event 5: As to dependents only, a Primary Enrollee becoming entitled to Medicare.

PERIODS OF CONTINUED COVERAGE

Qualified Beneficiaries may continue coverage for 18 months following the occurrence of Qualifying Event 1.

This 18 month period can be extended for a total of 29 months, provided:

1. a determination is made under Title II or Title XVI of the Social Security Act that an individual is disabled on the date of the Qualifying Event or became disabled at any time during the first 60 days of continued coverage; and
2. notice of the determination is given to the employer during the initial 18 months of continued coverage and within 60 days of the date of the determination.

This period of coverage will end on the first of the month that begins more than 30 days after the date of the final determination that the disabled individual is no longer disabled. The Primary Enrollee must notify the employer within 30 days of any such determination.

If, during the 18 month continuation period resulting from Qualifying Event 1, the Primary Enrollee's dependents experience Qualifying Events 2, 3, 4 or 5, they may choose to extend coverage for up to a total of 36 months (inclusive of the period continued under Qualifying Event 1).

The Primary Enrollee's dependents may continue coverage for 36 months following the month in which Qualifying Events 2, 3, 4 or 5 occur.

Under federal COBRA law, when an employer has filed for bankruptcy under Title II, United States Code, benefits may be substantially reduced or eliminated for retired employees and their dependents, or the surviving spouse of a deceased retired employee. If this benefit reduction or elimination occurs within one year before or one year after the filing, it is considered a Qualifying Event. If the Primary Enrollee is a retiree, and has lost coverage because of this Qualifying Event, he or she may choose to continue coverage until his or her death. The Primary Enrollee's dependents who have lost coverage because of this Qualifying Event may choose to continue coverage for up to 36 months following the Primary Enrollee's death.

ELECTION OF CONTINUED COVERAGE

The Primary Enrollee's employer shall notify Delta in writing within 30 days of Qualifying Event 1. A Qualified Beneficiary must notify his or her employer in writing within 60 days of Qualifying Events 2, 3, 4, or 5, or within 60 days of receiving the election notice from the employer. Otherwise, the option of continued coverage will be lost.

Within 14 days of receiving notice of a Qualifying Event, the employer will provide a Qualified Beneficiary with the necessary benefits information, monthly Premium charge, enrollment forms, and instructions to allow election of continued coverage.

A Qualified Beneficiary will then have 60 days to give the employer written notice of the election to continue coverage. Failure to provide this written notice of election to the employer or the administrator within 60 days will result in the loss of the right to continue coverage.

A Qualified Beneficiary has 45 days from the written election of continued coverage to pay the initial premium to his or her employer, which includes the premium for each month since the loss of coverage. Failure to pay the required premium within the 45 days will result in loss of the right to continued coverage, and any premiums received after that date will be returned to the Qualified Beneficiary.

CONTINUED COVERAGE BENEFITS

The Benefits under the continued coverage will be the same as those provided to active employees and their dependents who are still enrolled in the dental plan. If the employer changes the coverage for active employees, the continued coverage will change as well. Premiums will be adjusted to reflect the changes made.

TERMINATION OF COVERAGE

A Qualified Beneficiary's coverage will terminate at the end of the month in which any of the following events first occur:

1. the allowable number of consecutive months of continued coverage is reached;
2. failure to pay the required Premium in a timely manner;
3. the employer ceases to provide any group dental plan to its employees;
4. the individual moves out of the plan's service area;
5. the individual first obtains coverage for dental benefits, after the date of the election of continued coverage, under another group health plan (as an employee or dependent) which does not contain or apply any exclusion or limitation with respect to any pre-existing condition of such person, if that pre-existing condition is covered under this plan;
6. entitlement to Medicare.

The employer or Primary Enrollee shall notify Delta within 30 days of the occurrence of any of the above events. Once continued coverage terminates, it cannot be reinstated.

TERMINATION OF THE EMPLOYER'S DENTAL CONTRACT

If the dental contract between the employer and Delta terminates prior to the time that the continuation coverage would otherwise terminate, the employer shall notify a Qualified Beneficiary (either 30 days prior to the termination or when all Enrollees are notified whichever is later) of that person's ability to elect continuation coverage under the employer's subsequent dental plan, if any. The employer must notify the successor plan of the Qualified Beneficiaries receiving continuation coverage so they may be notified of how to continue coverage under that plan.

The continuation coverage will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the DeltaCare program had such program with the former employer not terminated. The continuation coverage will terminate if a Qualified Beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premium to the new group benefit plan within 30 days of receiving notice of the termination of the DeltaCare program.

OPEN ENROLLMENT CHANGE OF COVERAGE

A Qualified Beneficiary may elect to change continuation coverage during any subsequent open enrollment period, if the employer has contracted with another plan to provide coverage to its active employees. The continuation coverage under the other plan will be provided only for the balance of the period that a Qualified Beneficiary would have remained covered under the DeltaCare program.]

If you have any questions or need additional information, call or write the Administrator:

Toll Free
(800) 422-4234

PMI Dental Health Plan
12898 Towne Center Drive
Cerritos, CA 90703-8579
(562) 924-8311

Did you know you could refer to our web site for a listing of DeltaCare Dentists?
Visit www.deltadentalca.org/pmi and click on the Dentist Directory, DeltaCare Dentists and All States. You can also change your facility assignment, change your mailing address, request ID cards or an Evidence of Coverage booklet online. From the home page, simply click on Contact Us, Customer Relations and the Online Customer Service Request for DeltaCare (administered by PMI).

DELTA DENTAL®
Delta Dental Insurance Company

1000 Mansell Exchange West
Building 100, Suite 100
Alpharetta, GA 30022
Local 770-645-8700
Nationwide 800-521-2651
Facsimile 770-518-4757

June 7, 2004

VIA EXPRESS MAIL

Hazel Mosby
Government of the District of Columbia
Department of Insurance, Securities and Banking
Insurance Products Division
810 First Street, N.E., Suite 701
Washington D.C. 20002

Re: **Delta Dental Insurance Company**
NAIC Company Code 81396
DeltaCare CSO Series Form Filing

Dear Ms. Mosby:

Delta Dental Insurance Company ("Delta") respectfully resubmits for approval the following *new and revised* forms:

MC-DDIC-DC(CDT4R) — Group Dental Service Contract *Rev. 05/04*
Originally approved by the department on 12/13/02. Bracketed information added so that contract can also be used with new CSO Plans.

DC-DDIC-EOC(CDT4R) — Group Evidence of Coverage *Rev 05/04*
Originally approved by the department on 12/13/02. Bracketed information added so that EOC can also be used with new CSO Plans

S-A-DDIC-DC(CSO4) — Plan Benefits for the CSO Plans *New*

S-B-DDIC-DC(CSO4) — Limitations and Exclusions for the CSO Plans *New*

The grace period has been changed to 31 days as requested. I understand from your notes that the Rates have been forwarded to the Actuarial Analysis Division, and that they are under review. Therefore, I am not resubmitting them. Please let me know if this is not correct.

Strike-out Versions:	Equivalent Approved CDT-4 Form
MC-DDIC-DC(CDT4R)	MC-DDIC-DC(CDT4)
DC-DDIC-EOC(CDT4R)	DC-DDIC-EOC(CDT4)
S-A-DDIC-DC(CSO4)	S-A-DDIC-DC(CDT4)
S-B-DDIC-DC(CSO4)	S-B-DDIC-DC(CDT4)

This submission contains an original and one copy of:

- This transmittal letter
- Each form submitted for approval
- Redline copies as indicated above
- Postage-paid, self-addressed envelope for return of copies indicating Department approval.

With this information, we respectfully request your review of this submission. We trust you will find these forms acceptable for approval and subsequent use in the District of Columbia. Should you have any questions or require further information, please do not hesitate to contact me by telephone, toll-free at (800) 801-7105, ext. 7726, direct at (562) 467-7726, by FAX at (562) 924-0185 or by mail at:

Delta Dental Insurance Company
12898 Towne Center Drive
Mail Stop UW410
Cerritos, CA 90703
srenner@pmi.delta.org

Thank you for your attention to this filing.

Sincerely,

Sandra S. Renner

Sandra S. Renner
Sr. Compliance Analyst

Enclosures

October 21, 2015

Dear Sir or Madam:

Enclosed for your review and approval are new benefit, limitation and exclusion Schedules S-A-D70-R16 and S-B-D70 for the DeltaCare® USA Program. The forms do not replace any on file with your Department. This filing is not ACA/PPACA related.

These forms will be used in conjunction with the Evidence of Coverage DC-DDIC-EOC(CDT4R), approved by the Department on July 6, 2004 and Contract MC-DDIC-DC(CDT4R), approved by the Department on July 6, 2004.

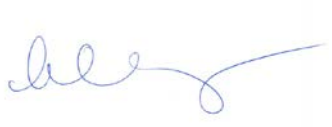
Schedules S-A-D70-R16, Description of Benefits and Copayments, and S-B-D70, Limitations and Exclusions of Benefits, are for use when our DeltaCare USA programs are sold to employer/employee, labor union or association groups located in the District of Columbia. These forms will not be used as or with an individual policy. These Schedules will be automatically updated annually for any changes required by the American Dental Association.

Addresses, phone numbers, websites, page numbers and numerical data are variable unless required by law. The schedules are bracketed in their entirety to allow for the addition and/or removal of procedures as well as modifications to the copayment ranges or frequencies at the request of groups who may require we change the benefit structure. In no event would any Schedule be completely removed.

The effective date for use of these forms will be the earlier of January 1, 2016 or the date the filing is approved or deemed approved by your Department.

Thank you for reviewing our filing. Please do not hesitate to contact me with any questions or concerns at (916) 861-1974 or akoelling@delta.org.

Sincerely,



Alisa Koelling
Regulatory Analyst